FORM #10
ASSESSMENT OF NEED
FOR HOME HEALTH CARE

10-25-00

THIS SECTION TO BE COMPLETED BY LEOFF-I CLAIMANT,
RESPONSIBLE FAMILY MEMER or CLAIMANT'S LEGAL REPRESENTATIVE.

Name of LEOFF-I Member: _____ Social Security #:_____

Residence address: _____ Telephone #: _____

_____

Responsible family member
or legal representative:_____ Telephone #: _____

Address: _____

_____

Home Health Care Agency: _____

Type of care provided: (24-hour care? hospice? medical treatments? other?)_____

_____

Charges for additional services/equipment: Yes ☐ No ☐ If "Yes", list type(s) of service and name(s) of service provider(s):

Attach itemized statement showing each service, cost and date provided (**required**).

Insurance purchased for this care? Yes ☐ No ☐ Medicare? Yes ☐ No ☐

Other medical insurance? Yes ☐ No ☐

Name of carrier:_____ Policy No.: _____

Signature: _____ Date: _____
LEOFF-I Member, Family Member/Legal Representative

THIS SECTION TO BE COMPLETED BY HOME HEALTH PROVIDER OR AGENCY

Service Provider:_____ Telephone #: _____

Address of agency: _____

_____

State licensure of agency (copy **required**): Yes ☐ No ☐ Professional liability insurance? Yes ☐ No ☐

Carrier and policy number:_____

Licensure/certification of care givers (copy of certificate for each caregiver **required**): Yes ☐ No ☐

Hourly rates (copy of rate sheet and itemized invoice for services provided **required**): _____

Prescribing physician: _____

Current level of care required (copy of care plan **required**): _____

_____

Medical treatments provided: _____

Signature: _____ Date: _____
Supervisor, Home Health Care

FORM #10
ASSESSMENT OF NEED
FOR HOME HEALTH CARE

10-25-00

THIS SECTION TO BE COMPLETED BY PRESCRIBING PHYSICAN

(Dictate for typing or print ONLY.)

Name of patient: _____ SSN:_____

Prescribing Physician: _____ Telephone: _____

Address:_____

_____

_____

Diagnosis upon admission to home health care:_____

_____

_____

History of illness/condition leading up to home health care: _____

_____

_____

_____

Patient's prognosis for recovery:_____

_____

Current level of functioning: _____

_____

Current medications (please attach printed list to include name, dosage, frequency:_____

_____

_____

Other providers involved in patient's health care: _____

_____

What treatment services have been prescribed--physical therapy, speech therapy, etc.? Attach treatment plans for each service (required.)

_____

_____

_____

Signature:_____ Date: _____

Prescribing Physician